



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

June 17, 2014

Ms. Tasha Thomas, Administrator  
Lodge At Otter Creek  
350 Lodge Road  
Middlebury, VT 05753-4498

Dear Ms. Thomas:

Enclosed is a copy of your acceptable plans of correction for the unannounced re-licensure survey and investigation of entity self-reports conducted on **April 23, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN  
Licensing Chief

PC:jl

## Division of Licensing and Protection

RECEIVED  
Division of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	JUN 11 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED  04/23/2014
NAME OF PROVIDER OR SUPPLIER  LODGE AT OTTER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE  350 LODGE ROAD MIDDLEBURY, VT 05753			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R100	Initial Comments:  An unannounced onsite re-licensure survey and investigation of entity self-reports was conducted on 4/21-23/14 by the Division of Licensing & Protection. There were no findings related to the self-report investigation. Findings for the re-licensure survey include:	R100			
R135 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.5 Assessment  5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the resident was assessed by a licensed nurse within fourteen days of admission for 3 of 7 sampled residents (Residents # 9, 11, and 12). Findings include:  1). Per record review R#9 was admitted to the facility on 7/7/2011 and the admission assessment was signed by the RN as complete on 8/6/2011.  2). Per record review R#11 was admitted to the facility on 10/6/2011. There is an admission assessment dated 10/10/2011 which is not completed (sections G, H, and J) or signed by the RN.	R135	Please see attached plans of correction.		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

(X6) DATE

RN Nurse Manager

6-9-14

STATE FORM

6899

0VI211

If continuation sheet 1 of 10

## Division of Licensing and Protection

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R135	Continued From page 1  3). Per record review R#12 was admitted to the facility on 2/12/2010 and the admission assessment was signed by the RN as complete on 3/17/2010.  In an interview on 4/22/14 at 3 PM the Manager/ Health Services Director confirmed that all assessments done would be in the electronic record and there were no other assessments available than the ones in the electronic record.	R135		
R136 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.7. Assessment  5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that each resident was reassessed annually, within the required time frames, for 3 of 7 in the sample (Residents # 10, 11, and 12) . Findings include:  1). Per record review R#10 had an admission assessment dated 4/18/2011 and reassessments on 6/5/2012, and 6/23/2013.  2). Per record review R#11, admitted on	R136		

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R136	<p>Continued From page 2</p> <p>10/6/2011 does not have a signed admission assessment, an assessment dated 10/10/2011 is not completed and not signed by the RN. An assessment dated 2/22/2012 is not signed by the RN. Assessments dated 2/12/2013 and 4/16/2014 are completed and signed.</p> <p>3). Per record review R#12 had an admission assessment dated 3/17/10 and reassessments dated 8/10/2011, 8/15/2012, and 9/8/2013.</p> <p>In an interview on 4/22/14 at 3 PM the Manager/ Health Services Director confirmed that all assessments done would be in the electronic record and there were no other assessments available than the ones in the record.</p>	R136		
R145 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p> <p>Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure the development of a written plan of care for each resident that describes the care and services necessary to assist the resident to maintain independence and well-being for 2 of 7 residents reviewed (Residents #7 and #8). Findings include:</p>	R145		

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R145	<p>Continued From page 3</p> <p>1). Per record review R#7 experienced an increase in hematuria (blood in the urine) on 3/31/2014 following a urinary procedure. Additionally in a note dated 4/2/2014 it states that the resident is experiencing dizziness. There is no revision to the care plan regarding monitoring urine for output and hematuria or for making accommodations in mobility related to the dizziness. The resident had a blockage of his Suprapubic catheter on 3/8/2014 and the ER was unable to replace it at that time. A Foley catheter was placed until a Suprapubic catheter can be placed at the end of March. The care plan was not revised to reflect the temporary Foley and any care such as catheter care or monitoring the condition of the site.</p> <p>2). Per record review, on 2/4/2014 R#8 was ambulating outside the facility and fell. S/he was transported to the hospital where it was discovered that s/he had a Left Fractured Humerus and returned with a prescription for Vicodin and a sling and shoulder immobilizer in place. Additionally a motion sensor was placed in the resident's room to alert staff when s/he was up. On 2/25/2014 the resident returned from a doctor's appointment with orders to keep brace in place at all except for bathing when it may be removed. Use stockinette under the brace, May discontinue use of the sling when pain subsides, and May move elbow as tolerated without limit. There is no revision of the care plan to reflect these instructions for care to staff.</p> <p>In an interview on 4/23/2014 at 2:20 PM the HSD confirmed that the above updates had not been added to the plan of care for residents #7 and 8 as above.</p>	R145		

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R162 R162 SS=E	<p>Continued From page 4</p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that delegated staff did not administer medications for which there was a complete physician's order which included parameters for administration of multiple PRN (as needed) analgesic/anti-inflammatory medications for 4 of 7 residents reviewed . Findings include:</p> <p>Per review of Physician's Orders for residents in the sample the following was identified:</p> <p>1). Per Physician Orders for resident #8 the resident has orders for Acetaminophen 650 mg PO (by mouth) every 6 hours for pain or fever over 101 as needed and Ibuprofen 400 mg PO every 4 hours for pain or fever not to exceed 6 doses in 24 hours. There is no clarification regarding the circumstances for administering one medication over the other for delegated staff.</p> <p>2). Per Physician's Orders for resident #9 the resident has orders for: Acetaminophen 650 mg PO every 4 hours for pain or fever over 101 as needed, Advil (Ibuprofen) 400 mg PO every 6 hours as needed for pain, Ibuprofen 400 mg PO every 4 hours as needed for pain or fever not to exceed 6 doses in 24 hours, and Tylenol</p>	R162 R162		

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R162	<p>Continued From page 5</p> <p>(Acetaminophen) 325 mg PO give 2 tabs to equal 650 mg every 6 hours as needed for pain, Vicodin (Hydrocodone/Acetaminophen) 5/500 PO Give 1 tab for mild pain (1-5) every 6 hours as needed, and Vicodin (Hydrocodone/Acetaminophen) 5/500 mg PO Give 2 tabs for severe pain every 6 hours as needed. There are no parameters to direct delegated staff regarding when to use one or the other medication other than the specifics for Vicodin and there are no orders regarding the maximum daily dose for Acetaminophen (usually 3-4 G daily or 2.6 G for long term use) for delegated staff.</p> <p>3). Per Physician Orders for resident #10 the resident has orders for Tylenol (Acetaminophen) 650 mg PO (by mouth) every 6 hours for pain as needed and Ibuprofen 400 mg PO three times a day as needed for pain. There is no clarification regarding the circumstances for administering one medication over the other for delegated staff.</p> <p>4). Per Physician Orders for resident #12 the resident has orders for Acetaminophen 650 mg PO (by mouth) every 6 hours for pain or fever over 101 as needed, Ibuprofen 400 mg PO every 4 hours for pain or fever not to exceed 6 doses in 24 hours, and Tylenol 500 mg PO as needed three times a day for pain. There is no clarification regarding the circumstances for administering one medication over the other for delegated staff.</p> <p>In an interview on 4/23/2014 the Health Services Director confirmed that the orders as stated are the current orders available for the above residents.</p>	R162		

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R188 R188 SS=D	<p>Continued From page 6</p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.12.b.(2)</p> <p>A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that resident records for 2 of 7 residents reviewed included progress notes regarding any accident or incident and subsequent follow-up. Findings include:</p> <p>1). Per record review resident #7 had a suprapubic catheter in place. In a note on 3/8/2014 it is stated that the resident's catheter was not draining and that he had refused to go to the Emergency Room (ER). Again on 3/9/2014 the resident had no urine in the urinary collection bag but was going to the Physician's office. When he returned to the facility a note indicated that he has a Foley catheter in place because the suprapubic catheter could not be reinserted due to tissue regrowth. The resident was educated</p>	R188		

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R188	<p>Continued From page 7</p> <p>regarding self-management of a foley catheter. There is no follow-up note written until the post surgical note on 3/26/2014 to indicate the resident's management and the function of the temporary catheter.</p> <p>2). Per record review resident #8 fell on 2/4/2014 when he was walking out side the facility. He was taken to the ER where a Left (L) Humeral Shaft Fracture was discovered as well as Hyperkalemia according to the note written on his return. He returned with a sling and strap arm immobilizer, and a prescription for Vicodin. On his return he was provided a pendant to call for help and a motion censor was placed in his room to alert staff when he was up. The next note written was on 2/9/2014 when it is noted that he was resting in bed with his L arm swollen from elbow to fingertips. According to the note he was advised to rest with his arm elevated and with ice. The next note written is on 2/17 stating that the resident was seen by CVO (Champlain Valley Orthopedics) and that he would be casted. The last note regarding the fracture was on 2/25 stating that he had returned from the MDs and may move as tolerated and remove the sling to bathe.</p> <p>There is no indication in the notes of assessing CMST (color, motion, sensation, and touch) or pain or of how the resident was managing the injury. There is no indication of how effective the ice and elevation were nor if the interventions were successful.</p> <p>In an interview on 4/22/14 at 3:0 PM the Health Services Director confirmed that the noted in the electronic record were the only noted available.</p>	R188		

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R221 R221 SS=D	<p>Continued From page 8</p> <p>VI. RESIDENTS' RIGHTS</p> <p>6.7 Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the resident with an accounting of all transactions at least quarterly. Resident funds must be kept separate from other accounts or funds of the home.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to assure that the residents having requested that the facility manage funds for them are provided an accounting of all transactions at least quarterly for 1 applicable resident in a sample of 7. Findings include:  Per staff interview the facility manages funds for resident #13. In an interview on 4/22/2014 at 2:45 PM the Business Office manager stated that s/he was unaware of the requirement that quarterly statements be issued to residents whose funds are managed and that no statements are issued.</p>	R221 R221		
R314 SS=D	XI. RESIDENT FUNDS AND PROPERTY	R314		
	11.2 If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly			

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R314	<p>Continued From page 9</p> <p>statement, and keep all resident funds separate from the home or licensee's funds</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview the facility failed to assure that the residents having requested that the facility manage funds for them are provided an accounting of all transactions at least quarterly for 1 applicable residents in a sample of 7. Findings include:</p> <p>Per staff interview the facility manages funds for resident #13. In an interview on 4/22/2014 at 2:45 PM the Business Office manager stated that s/he was unaware of the requirement that quarterly statements be issued to residents whose funds are managed and that no statements are issued.</p>	R314		

## **TLOC Plan of Correction**

### **R135**

#### **Deficiency #1**

5.5 Assessment 5.7.b: "If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency."

Deficiency: "Based on record review and staff interviews the facility failed to assure that the resident was assessed by a licensed nurse within 14 days of admission for 3 of 7 sampled residents (Residents #9, 11 and 12)"

- #1: Action to correct deficiency: On 5/29/14, an admission checklist was created to be utilized by nursing, for all admissions with requirements noted for assessments per licensing regulation.. Specified on the admission checklist is completion of sections A.0, A.1 and L.1 on day of admission with final assessment completed within 14 days of admission in entirety. See enclosed admission checklist
- #2: Measures to assure that this dose not occur: Admission checklist to be completed by licensed nurse, completing admission checklist for every resident admitted after 5/29/14.
- #3: How corrective action will be monitored: Completion of the admission checklist will be presented to Health Services Director, which will require his/her signature to verify completion of assessments. A copy of the admission check list will be placed in residents chart.

### **R136**

#### **Deficiency #2**

5.7 Assessment 5.7.c: "Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition."

Deficiency: "Based on record review and staff interview the facility failed to assure that each resident was reassessed annually, within the required time frames, for 3 of 7 in the sample (Residents #10, 11 and 12)."

- #1: Action to correct deficiency: As of 5/29/14, it is now required that each licensed nurse in charge of respective floors, will maintain in their electronic work calendar, which is shared with the Health Services Director and other licensed nurses, annual assessments for each resident according admission date.

R135, R136, R145, R162, R188, R221 + R314 POCs accepted w/ completion date of 6/9/14.  
Accepted 6/12/14 mlhigginsRN|PMC

#2: Measures to assure that this dose not occur: A wall chart will be maintained in Health Services Directors office, with month of move-in for residents to ensure completion of annual assessments. Health Services Director to chart audit assessments monthly.

#3: How corrective action will be monitored: On the 15th of each month, starting in June 2014, Health Services Director will audit charts of those residents requiring annual assessment based on move-in date and wall chart. First nurse's meeting of the month will have agenda topic added to discuss wall chart for resident's requiring annual assessments. See enclosed Nurse's Meeting Agenda.

## R145

### Deficiency #3

5.9.c (2): "Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being"

Deficiency: "Based on record review and staff interviews the facility failed to assure the development of a written plan of care for each resident that describes the care and services necessary to assist the resident to maintain independence and well-being for 2 of 7 residents (Residents #7 and #8)"

#1: Action to correct deficiency: It was discussed at the nurse's meeting on 5/28/14, that care plans require updating with acute medical or psychological changes. Care plans will continue to be updated quarterly prompted by electronic medical record and with care plan meetings bi-annually.

#2: Measures to assure that this dose not occur: Continued follow up by licensed nurses as well as Health Services Director.

#3: How corrective action will be monitored: The Health Services Director will review the 72 hour communication report on electronic medical record regarding acute resident issues and ensure care plan has been updated by chart audit.

## R162

### Deficiency #4

5.10 Medication Management: "Staff will not assist with or administer any medications, prescription or over-the counter-medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the residents record"

Deficiency: "Based on record review and staff interview the facility failed to assure that delegated staff did not administer medications for which there was a complete physician's order which included parameters for administration of multiple PRN(as needed) analgesic/anti-inflammatory medications for 4 of 7 residents reviewed"

- #1: Action to correct deficiency: On 5/29/14, all licensed nurse's were asked to audit charts on respective floors, for duplicate orders, and to seek clarification from prescribing physician. On review of deficiency, it was noted in standing orders that medications were prescribed as duplicates, standing order sheet was revised and initiated. See attached standing orders.
- #2: Measures to assure that this dose not occur: On 5/29/14, consolidated physician's orders were sent to primary care, for signature. Any residents with order redundancies had a statement attached, asking PCP for reconciliation.
- #3: How corrective action will be monitored: Bi-annually consolidated orders will be reviewed and sent to primary physician for reconciliation, with statement if redundancies are noted.

## R188

### Deficiency #5

5.12.b: "A record for each resident which includes: residents name; emergency notification number; name, address and telephone number of any legal representative, or if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any"

Deficiency: "Based on record review and staff interview the facility failed to assure that resident records for 2 of 7 residents reviewed included progress notes regarding any accident or incident and subsequent follow-up"

- #1: Action to correct deficiency: During nurses meeting (5/28/14), expectation of licensed nurse's to utilize electronic work calendar to monitor any acute issues or if follow up is required.
- #2: Measures to assure that this dose not occur: It is a requirement that licensed nurses will read 72 hour communication report on electronic medical record, and note any follow ups that may be required in previous nurse's notes, in a timely manner.
- #3: How corrective action will be monitored: Health Services Director will monitor nurse's notes on electronic medical record via 72 hour report to ensure appropriate follow up is taken and noted in residents electronic medical record.

## R221

### Deficiency #6

6.7: "Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the

resident with an accounting of all transactions at least quarterly. Resident funds must be kept separate from other accounts or funds of the home."

Deficiency: "Based on staff interview the facility failed to assure that the residents having requested that the facility manage funds for them are provided an accounting of all transactions at least quarterly for 1 applicable resident in a sample of 7."

#1: Deficiency correction: all of the following procedures have been added to the quarterly functions of the Business Office Manager.

Business Office Manager will have a reminder in electronic work calendar on a quarterly basis to ensure the residents receive proper account of all transactions

The Lodge at Otter Creek on 5/29/14, implemented a new Fund and/or Property Agreement (see attached), for all residents requesting funds to be managed by The Lodge at Otter Creek.

#### **R314**

##### **Deficiency #7**

11.2 "If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds"

Deficiency: "Based on staff interview the facility failed to assure that the residents having requested that the facility manage funds for them are provided an accounting of all transactions at least quarterly for 1 applicable residents in a sample of 7.

#1: Deficiency correction: all of the following procedures have been added to the quarterly functions of the Business Office Manager.

The Lodge at Otter Creek, on 5/29/14, implanted the use of a new resident letter/quarterly report (see attached) to be sent to all residents with funds on hand or activity during the quarter by the 15th of the month following the end of the quarter.



www.lodgesattherewick.com  
Middlebury, VT  
802-388-1220

www.shelburnebay.com  
Shelburne, VT  
802-985-9847

Residents Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**DRUGS**

**\*May be repeated up to a maximum of three times in one month.**

**\* Persistant presenting problem(s) require a drug consultation by the practitioner.**

\*please initial box

Pain /Fever	<input type="checkbox"/>	*Acetaminophen 650mg PO Q4H PRN headache, mild muscle, joint pain X 24 hours or fever above 100.4F Do not exceed 4000mg in a 24 hour period.
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Emergency	<input type="checkbox"/>	*If resident displays emergent symptoms (shortness of breath, chest pain, severe pain or CVA) that cannot be managed by The Lodge staff, the nurse may call 911 and send the resident to the emergency room for evaluation, then notify the physician.
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Oxygen Saturation	<input type="checkbox"/>	*Oxygen @ 2L/min via NC for O2 less than 92% or s/s of respiratory distress
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Indigestion	<input type="checkbox"/>	*Tums or generic brand 2 tablets (500mg) every 2 hours for indigestion or heartburn. Not to exceed 10 tablets in 24 hours.
Heartburn	<input type="checkbox"/>	*Magnesium/Aluminum suspension antacid 30 ml PO Q4H PRN x 24 hours /Mild epigastric pain without vomiting or chest pain.

Constipation	<input type="checkbox"/>	*Day 1 Administer MOM 30cc PO x1, if no BM in 3 days IF NO RESULTS: <input type="checkbox"/>	*Day 2 Administer one dulcolax suppository PR x1, if no BM in 4 days IF NO RESULTS: <input type="checkbox"/>	*Day 3 Administer 1 Fleet enema PR x1, if no BM in 5 days If no results after day 4 the nurse will notify physician.
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Loose stools	<input type="checkbox"/>	*Offer Imodium A-D (4mg), 2 tablets after first loose stool. diarrhea then offer (2mg) 1 tablet after each subsequent loose stool. not to exceed 8mg per day. If symptoms persist more than 2 days, notify physician
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Cough (without fever)	<input type="checkbox"/>	* Robitussin DM or/ Sugar free (when dx of DM) Robitussin 2tsp PO QID PRN for cough without fever. If symptoms persist for more than 5 days, notify PCP. <input type="checkbox"/>	* OTC cough drops
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Residents Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Ear Wax \_\_\_\_\_ \*Debrox 3 gtt BID per ear for four days flush with warm water on the 5th day.

For inability \_\_\_\_\_ \*MAY CRUSH MEDICATIONS IF NEEDED.  
to swallow medications  
Review medications for inability to be crushed with pharmacist.

Diet \_\_\_\_\_ \*Regular Diet until evaluated by Dietician.  
\*Nutrition consult upon admission to evaluate nutrition status and to assist with dietary and nutritional plan based on a resident's nutritional status, medical conditions and medications.  
\*Diet per dietition unless otherwise specified by physician.  
\*Consult Dietician for significant weight gain or loss.

Annual Influenza vaccine \_\_\_\_\_ Resident may receive an annual flu shot in recommended doses and method of administration.  
If NOT, the reason why NOT \_\_\_\_\_

Skin Integrity \_\_\_\_\_ \*Apply OTC Medical powder BID PRN for up to ten days.(Remedy anti-fungal or generic) If symptoms do not improve or worsen, Notify physician.  
\_\_\_\_\_ \*Telfa and petroleum w/gauze wrap and tape for abrasion or minor skin tear  
Nurse to assess for frequency of dressing change  
\_\_\_\_\_ \*Remedy Nutrashield with dimethicone 10% to treat or prevent irritation from wetness, urine or stools PRN  
\_\_\_\_\_ \*Remedy Calazime with Zinc Oxide 20% to treat or prevent irritation from wetness, urine or stools PRN  
\_\_\_\_\_ \*Hydrocortisone Cream 1% applied for pruritus  
Nurse to initiate-if lasting greater than 10 days notify MD.

Labs \_\_\_\_\_ \*Annual digoxin level for residents taking digoxin  
\*Annual fasting lipid level for residents taking statins.  
\*CMP for residents receiving diuretic therapy  
\*Monthly PT/INR for residents taking coumadin.  
\* Annual A1C for diabetics.  
\* Annual thyroid level for residents receiving thyroid replacement therapy.  
\*Annual PSA for BPH treatment  
\*Annual B12 for residents receiving B12 therapy  
\*UA C+S if indicated for hematuria, polyuria, dysuria or altered mental status

\_\_\_\_\_ "Family Trips" Family member may administer medications while resident is on leave of absence.

MD Signature \_\_\_\_\_ date \_\_\_\_\_

## Health Services Weekly Nurses Meeting Agenda

- Resident concerns (clinical and behavioral challenges/changes, challenges with families concerns, level of care concerns). Care plan revision review
- Who is out (residents who are out at the hospital and or rehab)
- Who visited residents away: discharge planner, discharge plan etc
- Concerns with care staff and/or medication technicians
- Environmental needs
- Nursing department concerns
- Annual assessment review

## The Lodge at Otter Creek Admission Check List

### Nursing Duties Prior to Move In:

\*\*\*\*\*Must be completed 24 hours prior to admission\*\*\*\*\*


Establish chart, label with resident's name


Review Physician's orders-any corrections, clarifications etc-fax to primary

Note special diet orders or restrictions-send notification to dining services

Provide advanced notice to care staff to expect admission, review information

Fax Physician's orders to Wilcox with insurance cards

### Nursing Duties Day of Admission:


PCC face sheet completed, a copy placed in residents chart

Inquire with resident about pain

Review Fire Safety Plan (defend in place)

Review medications and preferred medication times etc, reflect in E-MAR

Assess for level of support needed with ADLs

Review available aspects of daily care (housekeeping, laundry, preferred shower days-reflect in care plan)


Orient to apartment

Orient to dining services (tray service, shopping days, dining times, hydration cart)

Coordinate with maintenance (work order) for pendant, alarms etc

Complete a baseline AIMS assessment for residents receiving antipsychotic

Complete sections A.O, A.1 and L.1 (demographic information and medication section) on day of admission

Admission Summary Note:

- Skin Assessment
- Mobility Assessment
- Assistance with ADLs
- Pain Assessment
- Orientation
- Assistive Devices (hearing aids, dentures, walker)

**Care Staff Duties on Day of Admission:**


Introductions

Complete New Resident Form within 24 hours and filed in chart

Orientation of resident to community

**TO BE COMPLETED BY 14 DAYS AND APPROVED BY REGISTERED NURSE:**


Admission assessment completed in entirety, and copy placed in chart

Care plan completed, with copy in care plan binder

Submit this form to HSD when completed

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Health Services Director

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Date

**Fund and/or Property Management Agreement**

This agreement, between The Lodge At Otter Creek Senior Living Community and \_\_\_\_\_, resident of The Lodge At Otter Creek Senior Living Community, entered into on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, delegates The Lodge At Otter Creek Senior Living Community to assist in the management of funds and/or property for \_\_\_\_\_ in the following way:

*Assistance*

The Lodge At Otter Creek Senior Living Community shall disburse petty cash to \_\_\_\_\_.

*Terms*

\_\_\_\_\_ Dollars (\$\_\_\_\_\_) shall be disbursed to the resident on demand during normal business hours Monday - Friday.

*Funds and/or Property*

Unless otherwise requested by \_\_\_\_\_ or his/her Power of Attorney, not more than one thousand dollars (\$1,000.00) of resident money shall be kept locked in the Executive Office, acquired via cash deposit or personal check made payable to The Lodge At Otter Creek.

*Persons Involved*

Only the Executive Director, Mary Belanger, or the Business Office Manager, Karen Deering, shall disburse funds, and funds shall only be disbursed to the resident, \_\_\_\_\_. Funds shall be acquired from \_\_\_\_\_ and family.

The above assistance, terms, property and people involved all do hereby agree with his/her signature below.

RESIDENT or POA

Mary Belanger

Karen Deering

Date

Resident Name

Resident address

Resident address

Dear Resident Name,

In compliance with Vermont Residential Care Home Licensing Regulation 11.2, below please find your quarterly statement of petty cash receipts and disbursements.

Quarter Ending: 3/31/2014

Account Opening Balance: \$ 00.00 (account opened 4/25/11)

Last Statement Balance: \$ 00.00

Funds Received this quarter: \$ 00.00

Funds Disbursed this quarter: \$ 00.00

Ending Balance \$ 00.00

I, Mary Belanger, attest with my signature below that this statement is factual.

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Mary Belanger  
Executive Director

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Date